
Emergent Personality Disorders Among Adolescents with Anxiety Disorders

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Introduction

Since the introduction of well-defined diagnostic criteria in the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; APA, 1980), there has been a steady increase in the amount of research devoted to the study of personality disorder (PD), focusing initially and predominantly on adult populations. As currently defined, “A PD is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (APA, 2000; p. 685).” Research activity in the field of adolescent PD has also increased substantially in recent years, although there have been concerns about diagnosing PD among adolescents (Silk, 2008). Epidemiological research has suggested that although there are noteworthy differences in the phenomenology, assessment, and treatment of PD symptoms among adolescents and adults, the prevalence, comorbidity, and sequelae of PD may tend to be broadly similar in comparable adolescent and adult populations.

This chapter begins with a summary of research findings pertinent to the clinical presentation of emergent PD that may cooccur with anxiety disorders during adolescence, and a discussion of factors associated with the development of personality and anxiety disorders. Assessment instruments including structured diagnostic interviews, clinician-administered rating procedures, and questionnaires used to assess maladaptive personality traits in a dimensional manner are presented. The chapter concludes with a description of therapeutic interventions that have been found to be useful in treating adolescents with PD.

Clinical Presentation

In clinical and nonclinical populations, youths with emergent PD tend to experience higher levels of impairment or distress, and tend to have more severe and chronic symptoms than do youths without PD (Daley, Hammen, Davila, & Burge, 1998; Johnson, Hyler, Skodol, Bornstein, & Sherman, 1995; Johnson et al., 1999; Johnson, Cohen, Smailes, et al., 2000; Levy et al., 1999; Westen et al., 1990). In a variety of clinical populations, patients with anxiety disorders and cooccurring PD have been found to have lower levels of functioning, more persistent anxiety symptoms, and poorer long-term outcomes than those without PD (Sanderson, Wetzler, Beck, & Betz, 1993; Skodol et al., 1995).

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Most youths deal with a number of challenging developmental and psychosocial transitions between childhood and adolescence, both internally (e.g., changes in self-perception) and externally (e.g., changes in social roles). These transitions may be associated with the development of mild, moderate, or severe anxiety symptoms, and/or maladaptive personality traits. During the transition to adolescence, the development of self-consciousness, increased social comparisons, and the need for peer acceptance can collide with social stressors, such as exclusion and shame, to produce maladaptive outcomes in some children (Thomaes, Bushman, Stegge, & Olthof, 2008). Factors including unpopularity with peers, few extracurricular activities, and few positive relationships with adults during childhood may be associated with risk for the development of PD symptoms (Rettew et al., 2003).

Clinical Features of Specific Personality Disorders

Avoidant PD is defined, in the DSM-IV-TR (APA, 2000), as “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.” Antisocial PD, diagnosed only among individuals who are at least 18 years in age, is defined as “a pervasive pattern of disregard for and violation of the rights of others, occurring since age 15, and a history of conduct disorder by age 15.” Borderline PD is defined as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity.” Dependent PD is defined as “a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation.” Histrionic PD is defined as “a pervasive pattern of excessive emotionality and attention seeking.” Narcissistic PD is defined as “a pervasive pattern of grandiosity, need for admiration, and lack of empathy.” Obsessive-compulsive PD is defined as “a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.” Paranoid PD is defined as “a pervasive distrust

and suspiciousness of others such that their motives are interpreted as malevolent.” Schizoid PD is defined as “a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings.” Schizotypal PD is defined as “a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior.”

Comorbidity Between Anxiety and Personality Disorders

Potential comorbidity between anxiety and personality disorders is an important clinical consideration, because maladaptive personality traits tend to be associated with treatment complications, persistent anxiety symptoms, and poor outcomes (Brandes & Beinvenu, 2006; Skodol et al., 1995). Moreover, cooccurring disorders are often associated in a pathoplastic manner, with one disorder influencing the course, manifestation, and outcomes of the other. Such pathoplasticity frequently complicates treatment, but, in some cases, a cooccurring condition may be associated with reduced symptom expression. For example, there have been findings suggesting that anxiety disorders may have a protective or dampening effect in youths with antisocial characteristics (Tackett, 2006).

Studies in adolescent and adult populations have suggested that some types of anxiety disorders may be differentially associated with specific PDs. For example, McGlashan et al. (2000) have reported associations between social phobia and avoidant PD, and between OCD and obsessive-compulsive PD. Skodol et al. (1995) reported that among patients with anxiety disorders, OCD was associated with obsessive-compulsive and avoidant PDs; that panic disorder was associated with borderline, avoidant, and dependent PDs; and that social phobia was associated with avoidant and obsessive-compulsive PDs.

Studies of maladaptive traits, such as behavioral inhibition and emotional dysregulation, have also findings that are informative about the potential

associations between anxiety and personality disorders among youths. Behavioral inhibition, a temperament characteristic that may be evident during early childhood, has been found to predict childhood and adolescent anxiety disorders, and may also be associated with the development of Cluster C PD traits (see Tackett, 2006). Research has suggested that delinquent adolescents with high levels of emotional dysregulation and inhibitedness may tend to have difficulties with social withdrawal and anxious–depressive symptoms (Krischer, Sevecke, Lehmkuhl, & Pukrop, 2007).

Longitudinal Associations Between Anxiety and Personality Disorders

Research has suggested that anxiety disorders during childhood may contribute to elevated risk for DSM-IV Cluster A and C PDs (Goodwin, Brook, & Cohen, 2005), and that PDs during adolescence may be associated with elevated risk for subsequent anxiety disorders (Johnson, Cohen, Kasen, & Brook, 2006). Borderline and schizotypal PD traits were associated with risk for agoraphobia, generalized anxiety disorder (GAD), obsessive–compulsive disorder (OCD), panic disorder, and social anxiety disorder. Dependent PD traits were associated with risk for agoraphobia, OCD, panic disorder, and social anxiety disorder. Histrionic PD traits were associated with risk for GAD and OCD; schizoid PD traits were associated with risk for panic disorder; and avoidant PD traits were associated with risk for OCD and social anxiety disorder (Johnson et al., 2006).

Factors Associated with the Development of Personality and Anxiety Disorders

Childhood Adversities and Development of Personality Disorders

Numerous studies have provided findings suggesting that childhood maltreatment, problematic parenting, parental loss, and adversities may

contribute to the development of PD and maladaptive personality traits during adolescence (e.g., Cohen, Brown, & Smailes, 2001; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Johnson et al., 2001; Johnson, Cohen, Chen, Kasen, & Brook, 2006). Low parental affection has been found to be associated with elevated risk for offspring antisocial, avoidant, borderline, depressive, paranoid, schizoid, and schizotypal PDs, and aversive parental behavior has been found to be associated with elevated risk for offspring borderline, paranoid, passive–aggressive, and schizotypal PDs (Johnson, Cohen, Chen, Kasen, & Brook, 2006).

Specific types of maltreatment or problems associated with upbringing may be differentially associated with risk for the development of specific types of PD traits. Among the significant associations in the research literature are findings suggesting that childhood abuse and emotional neglect may contribute to the development of avoidant PD (Johnson et al., 2005). In addition, individuals with avoidant PD have reported higher levels of parental shaming and intolerance, and childhood feelings of guilt (Stravynski, Elie, & Franche, 1989), and histrionic patients have reported high levels of parental control and low familial cohesion (Baker et al., 1996). Maternal inconsistency and over-involvement have been found to predict offspring borderline and histrionic PDs, respectively (Bezirgianian et al., 1993). Childhood physical and emotional abuses have been found to be associated with risk for dependent and obsessive–compulsive PDs, respectively (Johnson et al., 2005). High levels of parental control and over-protectiveness, along with low levels of family expressiveness have also been associated with dependent PD (Johnson et al., 2005).

Overprotective, authoritarian parenting may foster dependency by reducing opportunities for autonomous learning experiences and thereby preventing the child from developing a trans-situational sense of mastery (Bornstein, 1992). Such children may develop a self-concept dominated by themes of powerlessness and incompetence, as well as persistent fears of abandonment and negative evaluations by others. In this regard,

it is notable that dependent PD often cooccurs with anxiety disorders (Brandes & Beinvenu, 2006; Grant et al., 2005).

Attachment Difficulties

Attachment theorists have hypothesized that interruptions and disturbances in relationships with attachment figures during early childhood may contribute to the development of maladaptive attachment styles, which often persist into adolescence or adulthood (Bowlby, 1973, 1977, 1982). Bowlby observed a strong causal relationship between the quality of child–parent experiences and later ability to form emotional relationships, noting that difficulties in emotional capacity often manifest as neurotic symptoms (e.g., anxiety) and maladaptive personality traits (e.g., interpersonal avoidance). Research has supported the inference that insecure attachment style is associated with an elevated likelihood of PD (Tackett & Krueger, 2005).

Fossati et al. (2003) found that avoidant, depressive, paranoid, and schizotypal PDs were associated with avoidant attachment styles, and that dependent, histrionic, and borderline PDs were associated with anxious attachment styles. West et al. (1994) reported that dependent and schizoid PD were associated with showed that preoccupied (i.e., enmeshed) and dismissing (i.e., detached) attachment styles, respectively.

Difficulties in Psychosocial Development

Erikson's theory of psychosocial development (Erikson, 1963, 1968, 1980) provides a particularly useful framework for understanding how difficulties in relationships with caregivers and significant others may lead to difficulties with anxiety, and the development of maladaptive personality traits. Erikson (1963) hypothesized that there are eight major developmental stages during the human life span, each of which is characterized by a normative psychosocial "crisis." Each of these crises can potentially arise at any point in life as a function of psychosocial

forces or "hazards of existence" (Erikson, 1963, p. 274).

Erikson hypothesized that positive relationships with primary caregivers during childhood contribute to the child's capacity to develop a sense of basic trust, which forms the basis for his or her capacity to venture forth in the world (autonomy), take risks (initiative), and develop a cohesive sense of self (identity). Interpersonal experiences during childhood that disrupt this basic developmental sequence tend to be anxiety provoking and to create conditions for the development of maladaptive traits. For example, caregivers who invalidate the child's emotional reactions to the world or are insensitive to the child's emotional states run the risk of undermining the communicative function of emotion, which may lead to the child's inability to trust his or her emotional experience of the world (Linehan, 1993). This basic sense of relational mistrust, if it becomes persistent during childhood, increases the likelihood of feelings of shame, doubt, guilt, inhibition, reluctance to take risks, and identity difficulties during adolescence.

Erikson (1963; 1968; 1980) theorized that the process of identity development is the key developmental milestone during adolescence, and that the adolescent struggle for identity is the most prominent of the normative developmental crises. Identity consolidation during adolescence enables the developing youth to develop a sense of continuity with the past, meaning in the present, and direction for the future (Marcia, 1994). As such, identity consolidation forms the cornerstone of well being and the basis of self-esteem. Successful identity achievement eventuates in a clear sense of self, well-defined beliefs and values, and a place in the community. Failure to achieve an identity may be associated with feelings of anxiety, depression, and with a wide range of maladaptive personality traits (e.g., identity disturbances associated with borderline PD). Disruptions in the process of identity consolidation may, thus, contribute to the emergence of PDs and anxiety disorders during adolescence (Brandes & Beinvenu, 2006; Grant et al., 2005; Johnson, 1993; Lenzenweger et al., 2007).

Identity Diffusion, Object Relations, and Personality Disorders

Kernberg (1984; 1996) has set forth a theory of PD development that elaborated upon the mental representations associated with basic mistrust during early childhood, and the processes leading to identity diffusion. Kernberg's theory emphasizes the role of core impairments in the conceptions of self and significant others, or "object relations." According to Kernberg (2005), problematic interactions with significant others during childhood tend to be split into those that are ideal and pleasurable, as opposed to those that are painful, perceived as persecutory, and subsequently avoided. Ideal and painful memories are kept separate, according to object relations theory, until the maturing child can realistically integrate the two categories. Identity diffusion is hypothesized to occur when this split between idealized and painful representations of self and others persists through adolescence (Kernberg, 2005). Research has suggested that many adolescents with identity diffusion may have persistent object-relational difficulties attributable to childhood adversities including excessive frustration during infancy, childhood maltreatment, and family turmoil (Akhtar, 1992). Identity diffusion and severe interpersonal difficulties during adolescence have been found to be associated with PD symptoms (Crawford et al., 2004; Johnson, 1993; Wilkinson-Ryan & Westen, 2000).

Assessment and Diagnosis of Emergent Personality Disorders

Special Considerations for Assessment of Personality Disorders in Children and Adolescents

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; Fourth Edition, Text Revision), several diagnostic considerations should be used in assessing PDs among children and adolescents (APA, 2000). First, PDs are not to be diagnosed unless a

youth has maladaptive personality traits that deviate markedly from cultural expectations and are "...pervasive, persistent, and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder (APA, 2000; p. 687)." Second, the features of a PD must have been present for at least 1 year. Third, antisocial PD cannot be diagnosed in individuals under 18 years of age, and may only be diagnosed in individuals who have a history of conduct disorder with an onset by age 15 years. Moreover, it should be noted that some personality traits that may be regarded as being pathological when expressed during adulthood are considered relatively normal during adolescence (e.g., affective lability, impulsivity). Only those traits that deviate markedly from cultural expectations are to be considered symptomatic of a PD.

Diagnostic Instruments Used for the Assessment of Personality Disorders

Several diagnostic interviews and questionnaires are available for the assessment of PD during childhood or adolescence (see McCloskey, Kane, Morera, Gipe, & McLaughlin, 2007).

The Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Spitzer, Gibbon, & Williams, 1995) is a two-stage diagnostic system that includes a screening questionnaire and a semistructured clinical interview. During the SCID-II interview, clinicians determine whether affirmative responses on the questionnaire indicate the presence of PD symptoms. Research has supported the reliability and validity of the SCID-II (Ekselius et al., 1994; Jacobsberg et al., 1995; O'Boyle & Self, 1990; Skodol et al., 1991). SCID-II items have been used, in epidemiological research, to assess adolescent PD symptoms (e.g., Bernstein et al., 1993).

The Structured Interview for DSM-IV Personality Disorders (SIDP-IV; Pfohl et al., 1997) is a semistructured diagnostic interview, available in two different versions, one with items grouped by diagnosis and the other with items grouped topically. Research has supported the

reliability and validity of the SIDP-IV in adult and adolescent populations (Brent, Zelenak, Bukstein, & Brown, 1990; Pfohl et al., 1997).

The International Personality Disorder Examination (IPDE; Loranger, 1994) is a two-part instrument used for the clinical assessment of PDs. The first section is a 77-item screening questionnaire. The second component is a 99-item semistructured interview, which takes approximately 3 h to administer. A modified version of the IPDE has been used with individuals as young as 15 years (Lenzenweger, 2008; Lenzenweger et al., 2007). Research has supported the reliability and validity of the IPDE (Loranger et al., 1994).

The Personality Disorder Interview-IV (PDI-IV; Widiger et al., 1995) is a semistructured interview. Manualized administration of the PDI-IV usually takes 90–120 min. The PDI-IV items may be administered thematically or by diagnostic criteria. The thematic format assesses attitudes toward self and others, security of comfort with others, friendships and relationships, conflict and disagreements, work and leisure, social norms, mood, appearance and perception. Research has supported the reliability and validity of the PDI-IV (Widiger et al., 1995).

The Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV; Zanarini et al., 1996) is a 108-item semistructured clinical interview. The DIPD-IV takes approximately 90 min to administer. Research has supported the inter-rater reliability of the DIPD-IV (Zanarini et al., 2000).

The Personality Diagnostic Questionnaire-4th Edition (PDQ-4+; Hyler, 1994) includes a 100-item self-report questionnaire and a clinician-administered clinical significance scale (CSS) assessing impairment, duration, and timing of traits identified based on questionnaire responses. Research has supported the inter-item and test-retest reliability of the PDQ-4+ (Hyler et al., 1989; Trull, 1993). Although the PDQ-4+ has a high false-positive rate, research has supported its use as a screening instrument (e.g., Davidson et al., 2001), and PDQ-4+ items have been used for research in adolescent populations (e.g., Johnson et al., 1995).

Dimensional Assessment of Maladaptive Personality Traits

Consistent with recent developments in the assessment of PD symptoms in adult populations, considerable attention has been devoted, in recent years, to the dimensional assessment of maladaptive personality traits in children and adolescence (Tackett, Balsis, Oltmanns, & Krueger, 2009). Dimensional approaches may be more informative than categorical diagnoses, and data regarding adaptive and maladaptive traits can be integrated readily within a dimensional framework (see Cicchetti & Rogosch, 1996; Mulder, 2008; Silk, 2008). Historically, adult trait models have frequently been applied to younger age groups. However, in recent years, efforts have been made to develop age-specific personality models for children and adolescents (Tackett, 2006). Middle childhood and early adolescence may be a critical period for the development of PD, given the changing nature of social relationships during these years (Tackett et al., 2009).

The Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200-A; Westen, Shedler, Durrett, Glass, & Martens, 2003) is a Q-sort instrument, designed for the dimensional assessment of DSM-IV PD symptoms. The SWAP-200-A is a set of 200 descriptive statements, printed on cards, which clinicians rank-order based on their observations. The SWAP-200-A has been found to be a promising tool for assessing adolescent PD traits (Westen & Shedler, 2005).

The Dimensional Assessment of Personality Pathology-Basic Questionnaire for Adolescents (DAPP-BQ-A; Tromp & Koot, 2008), a 290-item questionnaire, is an age-appropriate version of the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley et al., 1992). Research has supported the reliability of the DAPP-BQ (e.g., Livesley et al., 1998) and the DAPP-BQ-A (Tromp & Koot, 2008).

The Dimensional Personality Symptom Item pool (DIPSI; DeClercq, De Fruyt, & Widiger, 2009), developed for the dimensional assessment of adolescent personality characteristics, assesses 27 lower-order facets and 4 higher-order factors

(i.e., disagreeableness, emotional instability, introversion, and compulsivity). The three latter factors are particularly pertinent to childhood anxiety disorders and cluster C PD symptoms. The emotional instability facets include reflecting anxiety, insecure attachment, ineffective stress coping, dependency, and inflexibility. The introversion domain facets include shyness and withdrawn tendencies. The compulsivity facets include perfectionism, extreme order, and extreme achievement striving associated with early manifestations of obsessive–compulsive PD.

Reliability and Validity of Personality Disorder Assessment in Adolescent Populations

Numerous studies have demonstrated that when different clinicians conduct independent ratings of PD diagnostic interviews, in adolescent samples, inter-rater agreement has ranged from moderate to high (Becker et al., 2002; Brent et al., 1990; Daley et al., 1999; Grilo et al., 1998; Guzder et al., 1996; Lenzenweger, 1999; Ludolph et al., 1990; Westen & Muderrisoglu, 2003). Research has indicated that PD traits tend to be moderately stable during adolescence (e.g., Barasch et al., 1985; Bernstein et al., 1993; Daley et al., 1999; Johnson, Cohen, Kasen, et al., 2000; Korenblum et al., 1987; 1990; Lenzenweger, 1999). Similar findings regarding the temporal stability of PD diagnoses and traits have been obtained from adult samples when similar retest intervals and assessment procedures have been used (e.g., Johnson et al., 1997; Johnson, Cohen, Kasen, et al., 2000; Loranger et al., 1994; McDavid & Pilkonis, 1996; Trull et al., 1998).

Support for the concurrent, construct, and predictive validity of adolescent PD diagnoses has been provided by research indicating that adolescent PDs are associated with significant impairment and distress, maladaptive personality traits, and elevated risk for Axis I disorders, interpersonal aggression, suicide, and other adverse outcomes (Bernstein et al., 1993; Brent et al., 1993, 1994, 1990; Daley et al., 1998, 1999; Grilo et al., 1997; Guzder et al., 1996; Johnson, 1993; Johnson

et al., 1995; Johnson et al., 1999; Johnson, Cohen, Smailes, et al., 2000; Levy et al., 1999; Pinto et al., 1996; Westen et al., 1990). Risk factors for borderline PD during childhood have been found to be similar to those associated with borderline PD during adulthood (Guzder et al., 1996). Adolescents with borderline PD have been found to have self-concept disturbances that are not accounted for by depressive traits (Pinto et al., 1996). Evidence of familial aggregation of PDs has been reported (Johnson et al., 1995), and PD traits have been found to have similar correlates in adolescent and adult samples (DeClercq & De Fruyt, 2003).

Prevalence of Personality Disorders Among Youths in the Community

The available evidence indicates that PDs may tend to be approximately as prevalent among adolescents as they are among adults in the general population. Estimates of the prevalence of DSM-III-R and DSM-IV PDs among adolescents in community and primary care settings, based on diagnostic interviews, have ranged from 6 to 17%, (Bernstein et al., 1993; Daley et al., 1999; Johnson et al., 1999; Lenzenweger et al., 1997; Zaider et al., 2000). The median of these PD prevalence estimates is approximately 11%. In comparison, it has been estimated that approximately 10% of the adults in the general population are likely to have a current PD (Oldham, 1994; Weissman, 1993). Moreover, evidence from clinical studies has indicated that when similar assessment procedures are administered, the prevalence of PDs among adolescent inpatients is nearly identical to the prevalence of PDs among adult inpatients (Becker et al., 2002; Grilo et al., 1998).

Treatment of Personality Disorder Symptoms in Youths with Anxiety Disorders

A number of therapeutic modalities have been developed for the treatment of PD symptoms in children, adolescents, and adults (see Freeman &

Reinecke, 2007; Kernberg, Weiner, & Bardenstein, 2000; Oldham, Skodol, & Bender, 2005). Detailed information regarding issues such as level of care, cross-cultural and gender issues, and the assessment and management of suicidality and behavior problems in patients with PD is presented in the *Handbook of Personality Disorders* (Oldham, Skodol, & Bender, 2005).

Cognitive Therapy

A variety of cognitive approaches, including cognitive therapy (CT; Beck et al., 1990), cognitive-behavioral therapy (Hayward et al., 2000), and schema therapy (Young & Klosko, 2005) have been developed for the treatment of PD. Cognitive therapies for PD focus on helping patients learn how to modify problematic thoughts and behaviors and to develop improved coping skills. Client misperceptions of the therapist are addressed directly and corrected to preserve the therapeutic alliance. Schema-focused therapy addresses the interaction of core psychological themes (e.g., experiences of abandonment or abuse) and maladaptive coping styles (e.g., surrender, avoidance, overcompensation). Cognitive therapy for PD and other disorders may be appropriate for youths who are 11 years of age or older, and capable of abstract thought (Ronen, 2007). Cognitive-behavioral therapy, which includes affective education, cognitive restructuring, and practicing, has been found to be an effective treatment for youths with a wide range of disorders, including social anxiety disorders and schizoid spectrum disorders (e.g., Hayward et al., 2000; Atwood, 2007). Schema-focused therapy has been found to be an effective treatment for patients with avoidant PD (Coon, 1994), and research has supported the efficacy of CT in the treatment of PD (Pretzer, 2004).

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is a structured treatment approach that combines cognitive-behavioral interventions with mindful-

ness meditation practices. DBT was originally developed as a treatment for individuals with Borderline PD and a history of self-injurious behavior, but has been used in recent years to treat both adolescents and adults with a variety of other psychiatric conditions (Koerner & Dimeff, 2000). DBT treatment is organized into stages, addressing the following: (1) self-harmful and suicidal behaviors; (2) behaviors that could lead to termination of treatment; (3) behaviors interfering with quality of life (substance abuse, high-risk sexual behavior, extreme financial difficulties, criminal behavior, unemployment, housing difficulties); and (4) life skills training. Treatment goals, agreed upon by therapists and clients, are defined behaviorally. Emphasis is placed upon maintaining clear communication, appropriately validating clients' thoughts, perceptions, and feelings, and a strong therapeutic alliance. DBT therapists verbalize belief in the client's inherent capacity to improve and overcome difficulties. Therapeutic validation is intended to enhance the therapeutic relationship, facilitate behavior change, and help the client to learn to self-validate (Swales, Heard, Williams, & Mark, 2000; Linehan, 1993).

DBT has been found to be particularly effective when individual psychotherapy, group skills training, and telephone consultations are employed concurrently. In individual sessions, the therapist and client typically set an agenda of behaviors to target at the beginning of each session. Diary cards, which clients complete throughout the course of a week, are used for setting the session agenda. "Problem-solving" is a core strategy of treatment and consists of behavioral and solution analyses in individual sessions. When conducting a behavioral analysis, the client and therapist collaboratively break down all the links in the "chain" between triggers and consequent thoughts, feelings, and behaviors. Solution analysis seeks to identify the choice points at which the client could handle situations more adaptively in the future. Clients are actively encouraged to make a commitment to try to attempt more adaptive strategies when future choice points occur.

Skills training is a central focus of DBT treatment, aimed at increasing adaptive behaviors

while simultaneously reducing maladaptive behaviors. A basic assumption of DBT is that clients engage in dysfunctional behaviors because they lack the skills to deal with difficult situations. Four skill modules are taught in the context of a group modality and include core mindfulness, distress tolerance, emotion-regulation, and interpersonal effectiveness skills. The skill modules target four characteristic problem areas, which include confusion about self, impulsivity, emotional instability, and interpersonal problems. Telephone “coaching” between outpatient therapy sessions is offered to assist clients in generalizing skills to their outside lives. Phone coaching additionally provides an avenue for clients to repair and enhance the therapeutic relationship (Swales, Heard, Williams, & Mark, 2000; Linehan, 1993).

Modifications of DBT in working with adolescents include involvement of caregivers, strategies to enhance motivation, attention and engagement, and length of treatment. Teaching skills to caregivers can foster skill generalization and decrease caregivers’ involvement in conflict within the home environment. Multifamily skills training groups, including youths and their caregivers, can help caregivers to learn behavioral skills alongside teens. Family sessions often include family behavioral analyses of problematic behaviors and directly target ineffective use of contingency management and invalidation (e.g., communications of nonacceptance and/or expressed belief that teens’ behavior is manipulative). Role-play and experiential exercises are used in skills groups with teams to facilitate engagement. Between-session assignments may be referred to as “practice exercises” as opposed to “homework” to decrease negative connotations associated with school. With adolescents, the duration of treatment may be shortened to maximize engagement, because teens may exhibit less entrenched personality problems than adults.

DBT has been found to be effective in treating adults with borderline PD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993). Several studies have yielded findings supporting the efficacy of DBT in adolescent populations (Desmond, 2008; Katz, Cox,

Gunasekara, & Miller, 2004; Rathus & Miller, 2002; Miller, Wyman, Huppert, Glassman, & Rathus, 2000). Research has suggested that the combination of DBT and family therapy may be especially useful in treating adolescents (Miller, Glinski, Woodberry, Mitchell, & Indik, 2002).

Psychodynamic Psychotherapy

A number of psychodynamic models including ego psychology, object relations theory, and attachment theory are relevant to the treatment of PD (Yeomans, Clarkin, & Levy, 2005). In therapy approaches based on self-psychology, therapeutic empathy is used in a nondirective manner to activate the innate potential of the patient. Client resistance is empathized with, rather than interpreted. Transference-focused psychotherapy (TFP), which is based on object-relations theory, is a more directive, manualized approach, involving a highly engaged therapeutic relationship and therapist interpretation (Kernberg et al., 1989). Attachment-based treatment focuses on helping the patient to develop a more secure attachment style in the context of the therapeutic relationship (Travis, Binder, Bliwise, & Horne-Moyer, 2001). Expressive-supportive psychotherapy emphasizes the expression of feelings in a supportive environment.

Research has suggested that psychodynamic therapy may be effective for older children and adolescents with emotional disorders, although interpretation of unconscious conflict may be of limited value with severely disturbed youths (e.g., Fonagy & Target, 1996). According to Bleiberg (2001), the principal goal of effective psychodynamic therapy with youths is to promote reflective functioning. In adult populations, expressive-supportive psychodynamic therapy has been found to be effective in the treatment of obsessive-compulsive and avoidant PDs (Barber, Morse, Kraukauer, Chittams, & Crits-Christoph, 1997). Brief dynamic therapy has been found to be effective in mixed Axis II samples (Winston et al., 1994), and therapy based on self-psychology has been found to be helpful in treating patients with borderline PD (Stevenson & Meares,

1992). In addition, time-limited dynamic psychotherapy has been found to promote the development of a more secure attachment style (Travis et al., 2001).

Mentalization-Based Treatment

Based on attachment theory, mentalization-based treatment (MBT) is a psychodynamic therapy that seeks to enhance individuals' capacity to understand their thoughts and feelings in the context of attachment relationships. MBT is based on the premise that disruptions in mentalization (i.e., "reflective function") occur as a consequence of disruptions in attachment during infancy and early childhood, resulting in problems including anxiety, depression, and cluster B PD symptoms. MBT, which includes individual, group, and family sessions, promotes the capacity for mentalization, and works with youths and family members to transform problematic attachments and coercive cycles into healing and sustaining relationships (Bateman & Fonagy, 2004). Group sessions are used to assist clients in practicing mentalization skills. Research has found MBT to be effective in improving functioning and in reducing impairment, suicidality, and psychiatric service utilization (Bateman & Fonagy, 2004, 2008; O'Malley, 2003).

Cognitive Analytic Therapy

Cognitive analytic therapy (CAT) is an approach that synthesizes elements of psychodynamic and cognitive therapy. Dysfunctional patterns of interpersonal behavior are hypothesized, by CAT therapists, to be based on problematic attempts to elicit response from others, referred to as reciprocal role procedures (RRPs) (Ryle, 2001). These RRPs (e.g., patterns of interaction such as "caring-cared for" and "rejecting-rejected") are derived from early interactions, or ongoing interactions in the case of children, with caretakers and peers. During the course of therapy, the CAT clinician generates diagrams depicting how RRPs tend to be enacted by the patient, and how others

tend to reciprocate. These diagrams are used to help patients understand the nature and interpersonal consequences of their RRPs. Research has suggested that CAT may be an effective treatment for adolescents with borderline PD symptoms (Chanen et al., 2008).

Family Therapy, Parent Training, and Multimodal Treatment Approaches

In addition to providing individual treatment, it is often essential to address contextual factors that may contribute to youths' anxiety and personality problems. Children and adolescents' symptoms may result, in part, from problems in the family home environment, such as marital difficulties, family conflict, or parental impairment (Bleiberg, 2001; Framo, 1970; Magnavita, 2007). Family therapy, marital therapy, and/or provision of health or social services to other family members may play an important role in providing adequate treatment to youths with anxiety and personality disorders. In some cases, it may be helpful to provide services assisting parents in optimal child-rearing skills and enhancing caregiver competence (Bleiberg, 2001; Brestan & Eyberg, 1998). Parent training programs using videotaped modeling in a group format and manualized parent training protocols based on operant behavior principles have been found to be effective interventions (Brestan & Eyberg, 1998). Multisystemic therapy that addresses all areas of an individual's life in a comprehensive manner has been found to be efficacious with high-risk youths (Brestan & Eyberg, 1998). School-based family interventions (Dishion & Kavanagh, 2000) and multimodal interventions including family and individual therapy with home visits (Brotman et al., 2008) can reduce problem behaviors and improve parenting for youths who are at high risk for adverse mental health outcomes. Social skill training has been found to be helpful in addressing skill deficits in individuals with PD (Lieberman, DeRisi, & Mueser, 1989; Sperry, 2003). For example, cognitive therapy, combined with social skills training in a group format, has been found to be particularly effective for the

treatment of avoidant PD (Alden, 1989). Group therapy, combined with multifamily skills training, has been found to be effective in treating suicidal adolescents (Rathus & Miller, 2002).

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